

ADVERSE ACTION REPORT

STATE LICENSURE ACTION

Report Number 7920000036407863

This report is maintained in: ☒ The National Practitioner Data Bank

☒ The Healthcare Integrity and Protection Data Bank

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A. REPORTING ENTITY

Entity Name: TEST ENTITY
Address: 6220 TEST STREET

City, State, ZIP: TEST CITY, VA 11111

Entity Internal Report Reference
(e.g., claim number): ENTREF-1011011

Name or Office: TEST POC
Title or Department: TESTING DEPARTMENT
Telephone: (111)222-3333

Type of Report: CORRECTION

Previous Report Number: 7920000036407823

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name: TEST2LNAME, TEST2FNAME TEST2MNAME JR
Other Name(s) Used: LKJ, LJK LJK LKJ
Gender: FEMALE
Date of Birth: 05/05/1975
Organization Name: TEST2ORGANIZATIONNAME
Work Address: TESTSTREET

City, State, ZIP: TESTCITY, SC 39845
Country:

Organization Type: REHABILITATION HOSPITAL (303)
Other, as Specified:

Home Address: TESTSTREETHOME

City, State, ZIP: TESTCITYHOME, LA 38945
Country:

Deceased: NO
Date of Death:

Federal Employer Identification Numbers (FEIN): 976987689

Social Security Numbers (SSN): 532-46-5675

**National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank**

P.O. Box 10832
Chantilly, VA 20153-0832

<http://www.npdb-hipdb.hrsa.gov>

DCN: 7920000036407863

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For authorized use by:

TEST ENTITY

Individual Taxpayer Identification Numbers (ITIN): 931-73-8763

National Provider Identifiers (NPI): 9876896789

Professional School(s) & Year(s) of Graduation: NEW TEST SCHOOL 2000

Occupation/Field of Licensure (Code): DENTIST (030)

State License Number, State of Licensure: 89768976, CA

Other, as Specified:

Specialty: DENTAL: PUBLIC HEALTH (D2)

Drug Enforcement Administration (DEA) Numbers: 978678968976

Unique Physician Identification Numbers (UPIN): 897689

Name(s) of Health Care Entity (Entities) With Which Subject
Is Affiliated or Associated (Inclusion Does Not Imply
Complicity in the Reported Action.):

Business Address of Affiliate:

City, State, ZIP:

Country:

Nature of Relationship(s):

Other, as Specified:

**C. INFORMATION
REPORTED**

Type of Adverse Action: STATE LICENSURE

Name of Agency or Program
that Took the Adverse Action

Specified in This Report: TEST AGENCY

Adverse Action Classification Code(s): REVOCATION OF LICENSE (1110)

Other, as Specified:

PUBLICLY AVAILABLE FINE/MONETARY PENALTY (1173)

Date Action Was Taken: 05/05/2001

Date Action Became Effective: 06/06/2001

Length of Action: PERMANENT

Years:

Months:

Days:

Total Amount of Monetary Penalty, Assessment

and/or Restitution: \$22.00

Is Subject Automatically Reinstated After Adverse
Action Period Is Completed?: YES

Description of Act(s) or Omission(s) or Other

Reasons for Action Taken: TEST DESCRIPTION

Basis for Action: PRACTICING BEYOND THE SCOPE OF PRACTICE (29)

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TEST ENTITY

Is the Adverse Action Specified in This Report Based on the
Subject's Professional Competence or Conduct, Which
Adversely Affected, or Could Have Adversely Affected, the
Health or Welfare of the Patient?: YES

Other, as Specified:

☒ Subject identified in Section B has appealed the reported adverse action.

Date of Appeal: 05/03/2002

**D. SUBJECT
STATEMENT**

If the subject identified in Section B of this report has submitted a statement, it appears in this section.

Queriers, please note:

The practitioner/subject entered the statement shown below in response to an earlier version of this report. The reporting entity changed the report after the practitioner/subject prepared the statement. As of the date this query response was processed, the practitioner/subject has not changed the statement in response to the changes in the report.

Date Submitted: 03/24/2005

I am the subject. This is my statement.

**E. REPORT
STATUS**

Unless one or more boxes below are checked, the subject of this report identified in Section B has not contested this report.

☐ If box is checked, this report has been disputed by the subject identified in Section B.

☐ If box is checked, at the request of the subject identified in Section B, this report is being reviewed by the Secretary of the U.S. Department of Health and Human Services to determine its accuracy and/or whether it complies with reporting requirements. No decision has been reached.

☒ If box is checked, at the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services. The Secretary's decision is shown below:

Queriers, please note:

The Secretary of the Department of Health and Human Services reviewed an earlier version of this report and entered the statement shown below. After the Secretarial Review decision and statement were entered, the reporting entity changed the report. The Secretary has not reviewed the current version of the report.

Date Submitted: 03/24/2005

Secretary Considering review.

Date of Original Submission: 03/21/2005

Date of Most Recent Change: 03/24/2005

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**F. SUPPLEMENTAL
SUBJECT
INFORMATION
ON FILE WITH
DATA BANKS**

The following information was not provided by the reporting entity identified in Section A of this report. The information was submitted to the Data Banks from other sources and is intended to supplement the information contained in this report.

Subject Name(s): TESTALTERNATELASTNAME, TESTALTFIRSTNAM TESTALTMIDNAME
JR
TESTALTTLNAME, TESTALTFIRST TESTALTMID

The Data Banks attempted to notify the Subject identified in Section B on 03/24/2005 at the address below, but the attempt was unsuccessful.

TESTSTREETHOME
TESTCITYHOME, LA 38945

END OF REPORT